



medical review

and advisory board

OF THE CALIFORNIA MEDICAL ASSOCIATION

Professional Liability

**A Statistical Study of Professional Liability
Claims in California: 1957 Report of
Medical Review and Advisory Board**

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A STATISTICAL STUDY of 700 professional liability incidents, claims and suits in California has been completed by the Medical Review and Advisory Board (MRAB) of the California Medical Association. The period covered is less than two years. Since a minimum of five years' data is considered essential to reliable statistics because of the latency of professional liability claims, this study is of value only as it indicates statewide trends or as it confirms previous findings reported^{1,2} for Alameda and Contra Costa Counties for the period 1946-1954. (The Alameda-Contra Costa study is the only one of its kind previously reported.) Future annual statistical reports will be made by the MRAB.

SOURCES OF DATA

Reports of incidents, claims and suits were made by three insurance carriers of group professional liability programs in California: (1) American Mutual Liability Insurance Company (AMLICO); (2) Hansen and Rowland (H & R) and (3) The Nettleship Company (TNC). AMLICO is the carrier for 23 Northern California county medical societies. TNC is the approved group carrier for nine Southern California county medical societies. Both H & R and TNC are approved for group programs by the Los Angeles County Medical Association.

PERIOD COVERED BY DATA

The detailed records of the 700 claims which are the subject of this study cover the following periods

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• The Medical Review and Advisory Board has completed a statistical study of 700 professional liability claims against physicians in 32 Northern and Southern California counties. The nearly statewide findings closely parallel those of a similar study of nine years' experience in Alameda and Contra Costa Counties. There appear to be no significant differences between the losses incurred by old as against young physicians, by general practitioners as against specialists. More female than male patients made claims; the greatest number of claims was made by patients between the ages of 26 and 45. The largest number of claims involved surgical cases, with obstetrical and gynecological surgery, orthopedic surgery and general surgery heading the list. Seventy-one per cent of claims were made by patients who had been treated in hospital.

of time: AMLICO, from May 1, 1955, to February 15, 1957; H & R, from March 1, 1956, to January 15, 1957; TNC, from November 1, 1954, to February 1, 1957. These are claims reported for and during the policy years as noted above; it does not include claims of earlier years which were paid or otherwise settled or closed during the period of the current study as defined above. Only claims in which a reserve was established or indemnity paid are reported in this study.

METHODS AND DEFINITIONS

A Report of Claim was made by the carrier for each claim or suit on which a reserve was established. Changes in status of claims were reported to MRAB as they occurred.

Definitions of terms are as follows:

Suit. A suit is the actual filing in court of a plea for recovery of damages from a physician for alleged malpractice.

Indemnity. Indemnity refers to payment made to the claimant.

Judgment. Judgment is the amount of money awarded by the jury and approved by the judge when the patient plaintiff wins his suit.

Expense. Expense includes the total cost of legal defense, court costs, cost of special investigation and cost of expert witnesses. Expense cost does not include insurance company overhead or salaries of company's personnel.

Reserve. Reserve is the figure set up by the insurance carrier in its best judgment as to what a case will eventually cost, taking into account the sum of expense and indemnity or judgment costs.

Cost. "Cost" as presented in the attached tables includes expense and indemnity or reserve.

Claim. For the purpose of this study, all cases with reserves reported to MRAB are called "claims."

CATEGORIES

Claims fall into a number of categories as follows: (1) Pending suits, not yet tried; (2) suits tried and won for the defendant physician; (3) suits tried and lost by the defendant physician; (4) suits tried, but on appeal; (5) suits settled by payment to the patient before or during trial; (6) claims on which there has been no formal suit but indemnity has been paid; (7) incidents reported by the insured physician, or complaints and claims made by the patient or his attorney, on which suit has not been filed but which the insurance company considers sufficiently serious to warrant setting up a claim file and establishing a reserve.

Statistical data on any current year or immediately preceding years include, largely, pending claims. Because of crowded court calendars, few suits have been tried. Final disposition has been made of only a few of the claims reported here. Only after four or five years will the outcome of enough of the cases have been determined to warrant statistical analysis of claims under the separate categories listed above. For that reason, most of the data reported here will lump all categories listed above into one, which will be called "claims." Where greater detail is indicated, the two categories used in this study are designated as follows:

Claims, Group A: (1) All suits, including pending suits, not yet tried, and suits that have been settled or tried, and (2) all claims on which suit was not filed, but which have been settled by payment of indemnity.

Claims, Group B: Claims falling under Category 7 (see foregoing definitions of categories) on which there have been no suit or other action to date, but for which the insurance company has established a reserve.

All dollar figures and cost comparisons reported in this study apply only to AMLICO, the approved insurance carrier in the Northern California societies (23 counties). In the case of Southern Cali-

TABLE 1.—General Summary of Claims in Present Study

	Number of Claims			Cost of Claims AMLICO
	AMLICO	H&R- TNC	Total	
Group A claims (1) suits pending, and/or (2) indemnities or judgments paid	77	148	225	\$386,163.00
Group B claims (no suit, no indemnity yet paid or other final disposition)	317	158	475	411,655.00
	394	306	700	\$797,818.00

Abbreviations: AMLICO = American Mutual Liability Insurance Company; H & R = Hansen & Rowland; TNC = The Nettleship Company.

TABLE 2.—Age of Physicians Against Whom Claims Were Made*

Age Group	Number of Doctors Who Had Claims		Cost of These Claims AMLICO only Per Cent of Total
	All Carriers Per Cent of Total	AMLICO only Per Cent of Total	
26 to 30.....	2.1	2.4	1.5
31 to 35.....	15.7	17.6	13.7
36 to 40.....	22.0	25.8	27.0
41 to 45.....	21.7	22.4	26.5
46 to 50.....	15.3	11.3	11.4
51 to 55.....	10.1	8.3	8.3
56 to 60.....	7.0	6.5	6.5
61 to 65.....	3.4	2.6	2.6
66 to 70.....	1.3	1.4	1.4
71 to 75.....	1.1	1.4	1.4
76 to 80.....	0.3	0.3	0.3
	100.0	100.0	100.0

* Age data on the physicians insured was not available.

fornia, only the number of cases is reported, as the two insurance carriers—H & R and TNC—have not disclosed dollar amounts, indemnities paid, judgments rendered, or reserves established. It should be noted at this point that the failure to disclose such financial data is not due to lack of cooperation of the insurance carrier, but rather to the fact that there are two competing carriers within the same locality, and it is understandably regarded as good business not to make such disclosures. The Medical Review and Advisory Board wishes to express its appreciation to all three carriers for the cooperation which they have rendered in furnishing this data.

The MRAB also wishes to express its appreciation to the California Physicians' Service for the run-off of the punch cards enabling us to proceed with the detailed analysis.

PRESENTATION OF DATA

Table 1 is a general summary of all claims and shows the distribution of Group A and Group B claims in this study. Since H & R and TNC are competitors in the Los Angeles program, we have not been able to show separately the data for each of

these two insurance carriers, but have combined them in this report. The wide difference between the proportion of Group A claims and Group B claims reported by the carriers in Table 1 is not necessarily significant, because the combined H & R plus TNC sample includes an earlier period in which only "serious" claims were reported. The longer period of time may also account for the greater number of suits in the H & R and TNC group of cases.

The AMLICO program insures 3,938 physicians as of the period of this study. The total cost of AMLICO's 394 cases is \$797,818. This includes both expense and indemnity for settled claims and reserves for pending claims in all categories. Group A claims account for \$386,163 of this amount; Group B claims account for \$411,655.

PHYSICIAN AGE AND SEX FACTORS

Table 2 shows the number of physicians in various age groups involved in claims. The amount of claims in dollars was available only from AMLICO. Age data on the total number of physicians insured was not available; consequently this table does not reflect or give any specific information with regard to the hazard of various age groups of physicians. It is of interest to note, however, that there is a clear correlation in the age incidence of physicians against whom claims were made for both the AMLICO-insured physicians and the physicians insured under all carriers. In addition, this table basically reflects the same age distribution as noted in the Sadusk study of 1955 for the Alameda-Contra Costa Medical Association.

A further analysis of the sex factor in physicians' claims was studied but it is not reported in tabular form. It was found that 3.3 per cent of physicians involved in claims were female. However, it is not possible to determine what the relative incidence of claims against male as compared with female physicians might be, since data was not available on the sex of all physicians insured. Correlation with the previous Sadusk study is close since that study revealed that female physicians accounted for 3.2 per cent of malpractice incidents.

PATIENT AGE AND SEX FACTORS

Table 3 shows the distribution of claimant patients by age groups. This analysis covers only 559 of the 700 claimants, since the age of 141 of the 700 claimants was not reported by the insurance companies. Of particular note is the large proportion of claimants in the infant age group (up to five years). The cost of these cases to AMLICO closely correlates to the number of claimants in the various age groups for all carriers.

Additional analyses were made of the age of

TABLE 3.—Distribution of Claims by Age of Patient (559 Claimants)

Age of Patient	Number of Patients Making Claims Per Cent of Total	Cost of These Cases AMLICO only Per Cent of Total
0 to 5.....	12.4	10.3
6 to 10.....	3.2	1.1
11 to 15.....	2.5	0.3
16 to 20.....	4.3	3.5
21 to 25.....	5.6	8.7
26 to 30.....	11.2	12.2
31 to 35.....	9.5	14.5
36 to 40.....	12.0	15.7
41 to 45.....	9.2	10.1
46 to 50.....	6.1	1.8
51 to 55.....	6.4	4.2
56 to 60.....	4.8	6.0
61 to 65.....	3.9	4.0
66 to 70.....	4.8	5.8
71 to 75.....	2.0	0.5
76 to 80.....	1.3	0.8
81 to 85.....	.....	.....
86 to 90.....	0.7	0.1
91 to 95.....	.....	.....
96 to 100.....	.....	.....
100 to 105.....	0.1	.....
	100.0	100.0

TABLE 4.—Distribution of Claims by Sex of Claimant

	Number of Claimants Per Cent of Total	Cost of Claims (AMLICO only) Per Cent of Total
Male	41	39
Female	59	61
	100	100

patients according to the type of injury claimed, but no significant variations were noted within the limitations of this study and consequently detailed data are not presented.

Table 4 shows distribution of claims by sex of the claimants. The number and the cost of claims by females exceeded those made by males. Similar disparity was previously noted in the Sadusk study of 1955, and possibly reflects the high hazard of obstetrics and gynecology.

TYPE OF MEDICAL PROBLEM

Table 5 shows distribution of claims cases by type of medical problem. Approximately 63 per cent of the total number of cases for all carriers and 62 per cent for AMLICO involved surgical cases. Claims in surgical cases accounted for approximately 70 per cent for the cost of cases in the AMLICO program. Next were internal medicine cases and then, in order, "other" or miscellaneous cases, equipment and radiological cases and blood transfusion reactions. The data in this table are strikingly similar to those reported in the study previously made of the Alameda-Contra Costa County experience for nine years of observation.

TABLE 5.—Distribution of Claims Cases by Type of Medical Problem

Type of Medical Problem	Number of Cases				Cost of Cases
	All Carriers		AMLICO		AMLICO
	No.	Per Cent	No.	Per Cent	Per Cent
Medical	118	16.8	63	16.0	19.4
Surgical	440	62.9	243	61.7	69.5
Radiological	25	3.6	12	3.1	3.0
Equipment	27	3.9	11	2.8	0.7
Blood transfusions	9	1.3	5	1.2	1.8
Other*	81	11.5	60	15.2	5.6
	700	100.0	394	100.0	100.0

* Falls in office, alleged assault or undue familiarity, absence of operation consent, and other unclassified types of injury.

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A study of the distribution of surgical cases (Table 6) showed that for all carriers the greatest number was in the field of obstetrics and gynecology and for AMLICO the greatest cost was for cases of that kind. Then followed, in order, orthopedics, general surgery and anesthesiology. Here again the data were essentially similar to those noted in the Alameda-Contra Costa County study. A special analysis to include cases involving retained foreign bodies following surgery revealed a substantial percentage and cost owing to claims of that kind.

TYPE OF PRACTICE OF PHYSICIAN

Table 7 brings out the fact, as previously noted in the Alameda-Contra Costa study, that there is no evidence to show that either the general practitioner or the specialist accounts for a greater proportion of medical malpractice cases. Information on the number of general practitioners and specialists insured was available only in the AMLICO program. Here, the general practitioners insured under the program numbered 41.9 per cent, and accounted for 43.4 per cent of cases and 40.9 per cent of the cost of cases. Specialists made up 58.1 per cent of the physicians insured; they accounted for 56.6 per cent of cases and 59.1 per cent of cost. If one takes into account all three carriers, essentially similar percentages prevail in the distribution of cases between the general practitioner and the specialist. Here, again, as in the Alameda-Contra Costa study, is evidence that medical malpractice hazards are not a reflection of the classification of practice of the physician, but as noted in the previous tabular data, are rather a reflection of the type of practice—surgical versus other medical fields.

A further analysis of cases is presented in Table 8 with regard to whether the physician was a general practitioner, was an American Board-certified specialist or a noncertified specialist. The data here are presented for information only; no conclusions may be drawn, since neither in the AMLICO program nor in any of the other programs was there specific

TABLE 6.—Distribution of Surgical Claims Cases Amongst Various Fields of Surgery

Type of Surgical Problem	Number of Cases				Cost of Cases
	All Carriers		AMLICO		AMLICO
	No.	Per Cent	No.	Per Cent	Per Cent
Obstetrics- gynecology	95	21.6	56	23.1	37.7
Orthopedics	86	19.5	46	18.9	23.6
General surgery ..	60	13.6	27	11.1	13.0
Ear, nose, throat ..	32	7.3	16	6.6	3.5
Plastic surgery	4	0.9	1	0.4	.....
Neurosurgery	8	1.8	5	2.1	4.0
Ophthalmology	21	4.9	8	3.3	0.8
Thoracic surgery ..	9	2.0	2	0.8	.....
Anesthesia	63	14.3	47	19.3	6.6
Proctology	7	1.6	3	1.3	1.5
Urology	19	4.3	11	4.5	2.3
Foreign bodies (left in surgery)	36	8.2	21	8.6	7.0
	440	100.0	243	100.0	100.0

TABLE 7.—Division of Claims Cases as Between General Practitioners and Specialists

Type of Practice	AMLICO only			All Carriers No. of Cases Per Cent
	Doctors Insured Per Cent	No. of Cases Per Cent	Cost of Cases Per Cent	
General practice	41.9	43.4	40.9	43.2
Specialists	58.1	56.6	59.1	56.8
	100.0	100.0	100.0	100.0

TABLE 8.—Division of Claims Cases as Between General Practitioners, American Board-Certified Specialists and Noncertified Specialists

Practitioners	AMLICO only		All Carriers No. of Cases Per Cent
	No. of Cases Per Cent	Cost of Cases Per Cent	
General practitioners	43.4	40.9	43.2
Certified specialists	37.1	44.1	37.9
Noncertified specialists	19.5	15.0	18.9
	100.0	100.0	100.0

data available on the division of insured physicians between certified specialty and noncertified specialty groups. As the Medical Review and Advisory Board program goes along, it is hoped that such data will be available from the carriers so that further analyses can be made.

Table 9 deals with the AMLICO study only, since the specific data presented was available only in that program. It casts light on the relative hazards of various fields of practice. In this table are represented the number of cases charged to each specialty and to general practice as compared with the percentage of those insured. Cost data is likewise included. These data would suggest that the person doing neurosurgery is the most hazardous physician to cover, with orthopedics next in line, and obstetrics and gynecology third. Also worthy of note is the

TABLE 9.—Distribution of Number of Cases and Costs of Cases Amongst Various Fields of Medicine

	Number of Doctors Covered; Per Cent of Total	Number of Cases; Per Cent of Total	Cost of Cases; Per Cent of Total	Number of Cases per 100 Doctors Covered in Field	Cost: Expense, Indemnity and Reserve, per Doctor in Each Field
Anesthesiologists.....	3.3	7.0	2.8	19	\$187.00
Dermatologists.....	1.9	1.7	1.9	7	218.00
Eye, ear, nose, throat.....	1.0	0.3	.....	.....	.....
Internists.....	13.1	4.0	5.3	4	85.00
Neurosurgeons.....	0.7	1.3	2.8	24	906.00
Obstetricians-gynecologists.....	5.5	7.0	12.1	12	471.00
Ophthalmologists.....	2.8	2.7	0.5	8	35.00
Orthopedists.....	3.5	6.2	11.6	27	762.00
Ear, nose, throat.....	1.6 (2.6*)	2.9 (3.2*)	0.6*	5*	52.00*
Pathologists.....	1.4	0.9	0.9	6	145.00
Pediatricians.....	4.9	2.6	4.1	7	199.00
Plastic surgeons.....	0.5	0.7	0.1	12	17.00
Proctologists.....	0.7	0.7	1.1	8	333.00
Psychiatrists.....	4.2	1.7	2.2	2	112.00
Radiologists.....	2.9	4.3	3.6	16	287.00
Urologists.....	2.3	3.5	1.0	19	100.00
Thoracic surgeons.....	0.5	0.5	0.0	11	4.00
General surgeons.....	7.2	8.5	8.3	9	258.00
Physical medicine.....	0.1	0.3	0.0	25	7.00
General practitioners.....	41.9	43.2	41.1	12	213.00
	100.0	100.0	100.0		
Total specialists.....	58	57	58.9		221.00
General practitioners.....	42	43	41.1		213.00
	100.0	100.0	100.0		

(279 of 3,938 doctors in the AMLICO program could not be identified as to field of practice. This is 7.3 per cent of total.)

*Eye, ear, nose, throat and ear, nose, throat combined.

TABLE 10.—Relative Incidence of Claims Against General Practitioners and Specialists in Various Fields of Medicine

Injury	General Practitioners			Specialists		
	All Carriers Number of Cases Per Cent	AMLICO Only		All Carriers Number of Cases Per Cent	AMLICO Only	
		Number of Cases Per Cent	Cost of Cases Per Cent		Number of Cases Per Cent	Cost of Cases Per Cent
Anesthesia.....	32	32	56	68	68	44
Dermatology.....	.....	.....	.....	100	100	100
Internal medicine.....	60	60	45	40	40	55
Neurosurgery.....	.....	.....	.....	100	100	100
Obstetrics-gynecology.....	53	54	49	47	46	51
Ophthalmology.....	19	20	24	79	80	76
Orthopedics.....	47	48	36	53	52	64
Ear, nose, throat.....	44	50	56	56	50	44
Pathology.....	.....	.....	.....	100	100	100
Pediatrics.....	40	40	21	60	60	79
Plastic surgery.....	.....	.....	.....	100	100	100
Proctology.....	14	33	5	86	67	95
Psychiatry.....	11	.....	.....	89	100	100
Radiology (1).....	24	11	4	76	89	96
Radiology (2).....	.....	.....	.....	100	100	100
Urology.....	21	18	24	79	72	76
Thoracic surgery.....	11	.....	.....	89	100	100
General surgery.....	50	48	45	50	52	55
Equipment failure.....	49	27	58	51	73	42
Foreign bodies left in surgery.....	33	38	35	67	62	65
Falls in office.....	56	62	86	44	38	14
Toxic drug reactions.....	55	55	51	45	45	49
Blood transfusions.....	50	40	66	50	60	34
Infection following injection.....	67	100	100	33	.....	.....
Physical medicine.....	.....	.....	.....	100	100	.....
Other*.....	61	68	60	39	32	40

Radiology (1) excludes deep therapy, radium. Radiology (2) includes deep therapy, radium.

*Includes: Absence of consent to operate, operating the wrong patient, alleged assault or undue familiarity, etc.

TABLE 11.—Claims of Errors in Diagnosis Related to Various Fields of Medicine and Kind of Practitioner (Number of Cases Includes All Carriers; Cost of Cases Pertains Only to AMLICO)

	All Injuries		Internal Medicine		Obstetrics-Gynecology		Orthopedics		Radiology		General Surgery	
	No. of Cases Per Cent	Cost of Cases Per Cent	No. of Cases Per Cent	Cost of Cases Per Cent	No. of Cases Per Cent	Cost of Cases Per Cent	No. of Cases Per Cent	Cost of Cases Per Cent	No. of Cases Per Cent	Cost of Cases Per Cent	No. of Cases Per Cent	Cost of Cases Per Cent
Noncertified specialists.....	13.5	12.3	15.0	15.0	10.0	6.2	13.3	.....	9.1	24.5	22.3	67.3
Certified specialists.....	31.0	43.5	10.0	.....	40.0	16.5	20.0	14.2	63.7	69.9	11.2	.....
General Practitioners.....	55.5	44.2	75.0	85.0	50.0	77.3	66.7	85.8	27.2	5.6	66.5	32.7
	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Errors in diagnosis also occurred in other fields. All claims made in proctology, dermatology, neurosurgery and psychiatry were against board-certified specialists. In pediatrics and thoracic surgery the claims were about equally divided between general practitioners and specialists. Errors in diagnosis were reported in no other fields.

fact that insurance carriers have traditionally classified plastic surgery as a hazardous field and have required that plastic surgeons pay a higher rate of premium than other surgeons. In this study, the data again suggests that the plastic surgeon does not represent an unusual hazard.

As to statements made in the paragraph above with respect to the hazard of various types of specialties, it should be remembered that this study is for a period of less than two years, and that no conclusions can be accurately drawn until we have carried on this type of analysis for from five to six years and have many more claims to analyze.

The warning to treat the results of this study with caution is repeated with regard to Table 10, which shows the particular fields in which the specialist or the general practitioner appear to encounter the greater malpractice hazards. Table 10 shows that in the fields of medicine and surgery in which general practitioners normally do little work, and therefore have little malpractice exposure, all or most of the cost and number of cases are charged to specialists. These fields are thoracic surgery, urology, plastic surgery, pathology, ophthalmology, neurosurgery, and, to a lesser extent, dermatology, proctology, psychiatry and radiology.

In anesthesiology and ENT (otolaryngology) specialists had the greater number of cases, but general practitioners' cases involved greater cost. The claims against specialists in anesthesia were for minor injuries for the most part, such as broken teeth and dentures—cases which are easily settled for comparatively minor amounts. General practitioners' cases involved claims of greater injury. Taking into account Table 7, where it is shown that general practitioners constitute approximately 42 per cent of AMLICO insured physicians, it would appear that there is a slight excess of anesthesiological and ENT hazard for general practitioners, inasmuch as they account for 56 per cent of the cost of anesthesiological injuries and for the same per cent of the cost of ENT injuries.

Both the number and cost of cases exceed the proportion of insured general practitioners (42 per cent) in internal medicine, obstetrics and gynecology and general surgery. The cost is lower than 42 per cent for general practitioners in orthopedics and pediatrics.

Specialists had the greater number of cases ascribed to "Equipment Failure," but the greater cost in this category, reflecting greater liability or injury, is charged to the general practitioners. This category includes diathermy and Bovie burns, broken needles and the like.

It would appear that specialists are a greater hazard than are general practitioners in regard to leaving foreign bodies in patients at operation. Perhaps this reflects the greater amount of surgical operation done by specialists, but data to support this conjecture are not available.

While "falls in the office" are not a major malpractice problem, it is interesting to note the significant difference between general practitioners and specialists with regard to claims of this order: The general practitioner's hazard is considerably greater, for which there is no apparent explanation. If this trend should continue through studies of malpractice data in future years, there should be investigation of the reasons for the high percentage of cost and the number of cases against general practitioners.

As to claims for toxic drug reactions, the hazards are slightly greater for general practitioners than for specialists. Toxic drug reactions appear to be accounting for an increasing number of claims.

Too few cases were reported in the categories of blood transfusions, infections following injections and in physical medicine for the results to be meaningful.

In the catch-all category designated as "other" injuries for the purpose of Table 10, are included absence of consent to operate, alleged assault, undue familiarity, operating upon the wrong patient, and other less frequent types of claims. Here, both in number of cases and in the cost of cases, the general

practitioner leads the specialist. Again, we are at a loss to explain a pronounced disparity, which is true of the experience of all carriers, North and South. If the trend continues, the problem must be analyzed in future years.

In Table 11 is an analysis of claims with regard to diagnostic errors. This problem has been analyzed specifically for internal medicine, obstetrics and gynecology, orthopedics, radiology and general surgery. Here it does appear clear that claims against general practitioners account for a relatively large number of cases in the fields of internal medicine, obstetrics and gynecology and orthopedics. On the other hand, it would appear that, insofar as costs are concerned, in the fields of radiology and general surgery claims against specialists make up an inordinate amount of the total. All the claims of diagnostic error in proctology, dermatology, neurosurgery and psychiatry were made against specialists.

THE HOSPITAL

In Table 12 malpractice claims are divided to show whether or not the claim is related to an occurrence in a hospital. These figures are represented for AMLICO only, since the H & R and TNC generally did not report whether or not a hospital was involved. At any rate, it is clear from this table that the majority of cases—71 per cent—occurred in the hospitals. This again was similar to data reported in the Alameda-Contra Costa study, in which it was noted that 70 per cent of the incidents occurred in the hospital, and 30 per cent in the physician's office or in the patient's home.

Data for the brief period covered were not sufficient for a study of the incidence of malpractice claims in various hospitals. Since the Alameda-Contra Costa report in 1955 analyzed the strikingly different incidence for malpractice claims among physicians in various hospitals in the Alameda-Contra Costa Counties area, this point was reviewed for the claims coming under the present study. Reports should be made in future studies on this subject, but suffice it to say at this time that—in general—an analysis (not presented in tabular form) revealed the same variation of malpractice claims among the hospitals in the Alameda-Contra Costa Counties area. Indeed, the similarity was striking, and it indicated that hospital medical staffs whose members in general had good records in the earlier study, continued during the last two years to have good records, while, generally speaking, those staffs whose members previously had had poor records continued to have poor records.

Another point studied, but upon which an adequate report cannot yet be made, is a comparison of counties as to the ratio of the number of claim

TABLE 12.—Data on Division of Claims Cases (for AMLICO Only) Showing Proportion Related to Incidents Occurring in Hospitals

	No. of Cases	Per Cent
Cases related to occurrences in hospitals	278	71
Cases related to occurrences elsewhere.....	116	29
	394	100

reports by physicians or by patients to the number of suits filed. Here, it is quite clear that in some counties physicians are cognizant of the medical malpractice problem and report potential malpractice claims early and have a consequently low ratio of suits and a low cost ratio in contrast to those counties in which physicians report very few potential malpractice suits, but have a relatively high proportion of suits and consequently a higher cost for their overall program.

SUMMARY

A detailed report of a study of 700 claims is made for a period of approximately one and a half years with the following results:

1. There is no basic difference in the overall malpractice hazard between the general practitioner and the specialist.

2. The medical malpractice hazard depends not upon whether the physician is a general practitioner or specialist, but rather upon the type of professional work done by the physician, with surgical fields accounting for approximately 62 per cent of claims.

3. The greatest number of surgical cases are in the field of obstetrics and gynecology. Orthopedics is next, and general surgery is third.

4. A study of the various specialties for the brief period covered would suggest that neurosurgery is the most hazardous specialty, orthopedics is next, and obstetrics and gynecology is third. There then follow in order: Proctology, radiology, general surgery, dermatology, and general practice. Internal medicine, ophthalmology, otolaryngology, plastic surgery, psychiatry, and urology are at the bottom of the list in this regard.

5. There would appear to be an increased hazard, of minor degree, for the general practitioner with regard to claims related to anesthesia, internal medicine, obstetrics and gynecology, ENT, general surgery, equipment failure, falls in office, toxic drug reactions and in unclassified injuries such as operating without consent, operating upon the wrong patient, alleged assault. On the other hand, the specialist seems to have a greater hazard in the fields of dermatology, neurosurgery, ophthalmology,

orthopedics, pathology, pediatrics, plastic surgery, thoracic surgery, proctology, psychiatry, radiology, and for foreign bodies left in the patient at operation.

6. The general practitioner would appear to have a greater hazard than the specialist for claims of diagnostic errors in the field of internal medicine, obstetrics and gynecology, and orthopedics. Specialists would appear to have greater hazard on this count in the fields of radiology and general surgery.

7. Approximately 71 per cent of malpractice cases are related to incidents that occur in hospitals. 459 Thirtieth Street, Oakland 9 (Sadusk).

REFERENCES

1. Sadusk, J. F., Jr.: An analysis of the professional liability program in Alameda-Contra Costa counties—1946-1954, A.C.C.M.A. Bulletin, May 1955.
2. Sadusk, J. F., Jr.: Analysis of professional factors in medical malpractice claims, J.A.M.A., 161:442-447, June 2, 1956.

A.M.A. Malpractice Film

A FILM entitled *The Doctor Defendant* is now available for distribution. It may be obtained by request from the Film Library, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois, giving a date as far in advance as possible. An alternate date should also be given.

This film is the second in a series on medicolegal problems being produced by the Wm. S. Merrell Pharmaceutical Company in cooperation with the A.M.A. and the American Bar Association. It is 16 mm., sound, black and white, and runs for 30 minutes. It is dramatic in style and points up ways of preventing professional liability claims and suits.

The film is a "must" for California physicians and should be shown at county medical association and hospital staff meetings.